

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4702HHA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER CAREPRO HOME HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 5280 SOUTH EASTERN A6 LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 00	<p>INITIAL COMMENTS</p> <p>This Statement of Deficiencies was generated as a result of a State Licensure re-survey conducted in your facility on 11/17/10 and finalized on 11/18/10, in accordance with Nevada Administrative Code, Chapter 449, Home Health Agencies.</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The patient census at the time of the survey was seven. Eight clinical records were reviewed. Seven employee records were reviewed. Three home visits were conducted.</p> <p>The following regulatory deficiencies were identified:</p>	H 00			
H128	<p>449.770 Governing Body; Bylaws</p> <p>3. The governing body shall appoint an advisory group of professional personnel, including one or more members who are practicing physicians,</p>	H128			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4702HHA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER CAREPRO HOME HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 5280 SOUTH EASTERN A6 LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H128	Continued From page 1 one or more professional registered nurses and representatives from other professional disciplines as indicated by the scope of the agency's program. This Regulation is not met as evidenced by: Based on document review and staff interview, it was determined the agency failed to appoint members to the advisory group of professional personnel that included representatives from the professional disciplines as indicated by the scope of the agency's program. 1. The attendance of the annual professional advisory committee meeting held on 9/6/10 did not include a home health aide or an occupational therapist. Scope: 3 Severity: 1	H128			
H134	449.770 Governing Body; Bylaws 9. The governing body shall ensure that the administrator has sufficient freedom from other responsibilities to permit adequate attention to the direction and management of the agency. This Regulation is not met as evidenced by: Based on interview, the agency's governing body failed to ensure the administrator had sufficient time from other responsibilities to oversee the direction of the agency. 1. On 11/17/10 at 9:30 AM, the administrator/director of professional services stated she worked a full time job at another facility and did not work at the facility on a full time basis. Duties such as confirming physician's orders were being completed by the office supervisor, a non-licensed employee. Scope: 3 Severity: 2	H134			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4702HHA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER CAREPRO HOME HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 5280 SOUTH EASTERN A6 LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H139	<p>449.776 Director of Professional Services</p> <p>2. The director of professional services shall:</p> <p>(a) Direct, supervise and coordinate the skilled nursing services and other therapeutic services provided by the agency.</p> <p>(b) Develop and revise written objectives for the care of the patients, policies and procedure manuals.</p> <p>(c) Assist in the development of descriptions of jobs.</p> <p>(d) Assist in the recruitment and selection of personnel.</p> <p>(e) Recommend to the administrator the number and levels of members of the nursing staff.</p> <p>(f) Plan and conduct orientations and continuing education for members of the staff engaged in the care of patients.</p> <p>(g) Evaluate the performance of the nursing staff.</p> <p>(h) Assist in planning and budgeting for the provision of services.</p> <p>(i) Assist in establishing criteria for the admission and discharge of patients.</p> <p>This Regulation is not met as evidenced by: Based on interview, personnel file review and policy review, the agency failed to provide performance evaluations of staff by the director of professional services.</p> <p>1. Review of the Nurse Supervisor policy 1.006.5 documented 1. "New staff members will be supervised/evaluated onsite unannounced twice per episode for the 1st four months of employment." 3. "Random onsite evaluation on all nursing staff will be at the direction of the Director of Nursing." 4. "Evaluation of nursing care and documentation of adult home care clients for compliance and regulatory standards."</p>	H139			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4702HHA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER CAREPRO HOME HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 5280 SOUTH EASTERN A6 LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H139	Continued From page 3 2. Two nursing personnel files were reviewed. The nurses's files lacked documented evidence of a supervised visit. 3. An interview with the Director of Professional Services (DPS) on 11/18/10 at 12:40 PM was conducted. The DPS confirmed that supervisory visits were not completed on the nursing staff. Scope: 2 Severity: 2	H139			
H141	449.779 Professional Advisory Group 2. The professional advisory group must include at least one member who is a practicing physician, one professional registered nurse, representatives from other professional disciplines as indicated by the scope of the agency's program and two members who are representatives of the general public served by the agency. At least one member of the advisory group may not be an owner or employee of the agency. The administrator or his designee shall attend all meetings of the advisory group. This Regulation is not met as evidenced by: Based on document review and staff interview, the agency failed to include on the professional advisory group representatives from all professional disciplines as indicated by the scope of the agency's program. 1. The attendance of the annual professional advisory committee meeting held on 9/6/10 did not include a home health aide or an occupational therapist. Scope: 3 Severity: 1	H141			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4702HHA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER CAREPRO HOME HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 5280 SOUTH EASTERN A6 LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H153	<p>449.782 Personnel Policies</p> <p>A home health agency shall establish written policies concerning the qualification, responsibilities and conditions of employment for each type of personnel, including licensure if required by law. The written policies must be reviewed as needed and made available to the members of the staff and the advisory groups. The personnel policies must provide for:</p> <p>7. The annual testing of all employees who have contact with patients for tuberculosis pursuant to NAC 441A.375; and</p> <p>This Regulation is not met as evidenced by: Based on record review, the agency did not ensure that the employees met the requirements of NAC 441A.375 concerning tuberculosis (TB) screening. (Employees #1,2,3,4,5,6 7)</p> <p>1. The files for Employees #1,2,3,4,5,6,and 7, lacked documented evidence of appropriate annual one-step TB skin test requirements in accordance with NAC 441A.375.</p> <p>2. The files for Employees #4 and 6, lacked documented evidence of a copy of a physical examination or certification from a physician that the employee was in a state of good health, was free from active tuberculosis and any other disease in a contagious stage.</p> <p>3. The files for Employees #1, 3, 4, 5, 6, 7, and 8, lacked documented evidence of the results of a positive skin test or a statement from a physician that the employee had tested positive for TB and did not have a two-step TB test on file.</p> <p>Scope: 3 Severity: 2</p>	H153			
H166	<p>449.788 Services to Patients</p>	H166			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4702HHA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER CAREPRO HOME HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 5280 SOUTH EASTERN A6 LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H166	Continued From page 5 1. If needed patient services are not available within the agency, the agency must assist in directing the patient to other community resources. This Regulation is not met as evidenced by: Based on interview and record review, the agency failed to provide a referral to a social worker as ordered by the physician. (Patient #4) 1. On 10/3/10, an order was written for evaluation from a physical therapist and social worker for patient #4. The agency was not licensed for social work services. The patient was not assessed by the physical therapist. 2. An interview with the office manager on 11/17/10 at 1:40 PM was conducted. The employee stated the physician and power of attorney were notified the agency did not provide a social worker. The employee acknowledged this information was not documented in the patient's record. The employee stated the physical therapist did not make an assessment due to the patient was not cooperative and refused the examination. The patient had a diagnosis of Alzheimer's disease. Scope: 1 Severity: 2	H166			
H180	449.793 Evaluation by Governing Body 6. The governing body shall provide for a quarterly review of 10 percent of the records of patients who have received services during the preceding 3 months in each services area. The members of the committee must include an administrative representative, a physician, a registered nurse and a clerk or librarian who keeps records. The clerk or librarian shall review the clinical records to ensure that they are	H180			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4702HHA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER CAREPRO HOME HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 5280 SOUTH EASTERN A6 LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H180	Continued From page 6 complete, that all forms are properly filled out and that documentation complies with good medical practices. The committee shall determine whether the services have been provided to the patients in an adequate and appropriate manner by all levels of service. The committee shall record any deficiencies and make necessary recommendations to the administrator. If the branch offices are small, two or more offices may establish one committee to review cases from each are. Each subunit agency must establish a committee to review cases within its area. Minutes of the committee's meetings must be documented and available for review. This Regulation is not met as evidenced by: Based on document review and staff interview, the agency failed to provide a physician and a clerk or librarian on the committee responsible for the quarterly review of patient clinical records. 1. The alternate Director of Professional Services (DPS) was the only staff member who provided the quarterly review of the patient clinical records. 2. An interview with the office manager and the DPS was conducted on 11/18/10 at 1:30 PM. Both employees acknowledged there was not a committee involved in reviewing the patient clinical records. Scope: 3 Severity: 2	H180			
H188	449.797 Contents of Clinical Records Clinical records must contain: 5. A copy of: (a) The patient's durable power of attorney for health care, if the patient has executed such a power of attorney pursuant to NRS 449.800 to	H188			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4702HHA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER CAREPRO HOME HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 5280 SOUTH EASTERN A6 LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H188	<p>Continued From page 7</p> <p>449.860, inclusive; and</p> <p>(b) A declaration governing the withholding or withdrawal of life-sustaining treatment, if the patient has executed such a declaration pursuant to NRS 449.600.</p> <p>This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to have a copy of the patient's durable power of attorney for health care and/or advanced directives documentation in the patient's record for 5 of 8 patient records reviewed. (Patients #1, #3, #4, #6, #7 and #8)</p> <p>1. Patient #1 was identified as having a living will. The file lacked documented evidence of a copy of the living will.</p> <p>2. Patient #3 was identified as having a living will. The file lacked documented evidence of a copy of the living will. The power of attorney was not addressed by the agency.</p> <p>3. The agency did not address the power of attorney or living will upon admission to the agency for Patient #4. A home visit was made on 11/17/10 and a copy of the power of attorney and living will was identified in the patient's medical record in the group home. The agency file lacked documented evidence of a copy of the living will or power of attorney .</p> <p>4. Patient #6 was identified as having a living will and power of attorney. The file lacked documented evidence of a copy of the living will or power of attorney.</p> <p>5. Patient #7 was identified as having a living will. The file lacked documented evidence of a copy of the living will. The power of attorney was not addressed by the agency.</p>	H188			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4702HHA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER CAREPRO HOME HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 5280 SOUTH EASTERN A6 LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H188	Continued From page 8 6. Patient #8 was identified as having an out of hospital Do Not Resuscitate (DNR). The file lacked documented evidence of a copy DNR. Scope: 3 Severity: 2	H188			
H200	449.800 Medical Orders 8. New orders are required when there is a change in orders, a change of physician or following hospitalization. This Regulation is not met as evidenced by: Based on observation, interview and clinical record review, the agency failed to obtain new orders for changes made to the plan of care for 3 of 8 patients sampled. (Patients #3, #5 and #6) 1. A home visit to Patient #3 was made on 11/17/10 at 4:50 PM. The patient's medications were reviewed. The patient had aspirin 325 mg, Vitamin C and Echinacea in the home. These medications were not listed on the agency's plan of care (POC). The patient was noted to be out of Zegerid. The home health registered nurse and patient were unable to identify when the patient took the last dose of Zegerid. The patient had been complaining of stomach pains and had been counseled on diet changes. An interview with the RN revealed the nurse would ask the patient if she was taking her medications, but did not reconcile the medications against the POC. The nurse explained the medications are checked against the POC on admission and re-certifications. The record lacked documented evidence that the physician was notified of the additional medications.	H200			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4702HHA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER CAREPRO HOME HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 5280 SOUTH EASTERN A6 LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H200	<p>Continued From page 9</p> <p>2. A home visit to Patient #5 was made on 11/17/10 at 6:20 PM. The patient's medications were reviewed. The patient had Vitamin C, cardiovascular vitamins and ocuvite in the home. The patient stated she was taking 3000 mg of Vitamin C twice a day. These medications were not listed on the agency's POC.</p> <p>An interview with the RN revealed the nurse would ask the patient if she was taking her medications, but did not reconcile the medications against the POC. The nurse explained the medications are checked against the POC on admission and re-certifications. The record lacked documented evidence that the physician was notified of the additional medications.</p> <p>3. Patient #6's clinical record was reviewed. The progress note from the admitting physician, dated 7/30/10 revealed the patient was on the following medications: Nexium 40 mg, Vesicare 10 mg, Lipitor 40 mg, Niaspan 100 mg, Bayer (aspirin) 325 mg, Zoloft 50 mg, Pepcid 40 mg, Folic Acid, Vitamin D multivitamins.</p> <p>The POC documented the patient was on the following medications: Niaspan 1000 mg, Lipitor 40 mg, Nexium 40 mg, Vesicare 10 mg, Aspirin 20 mg</p>	H200			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4702HHA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER CAREPRO HOME HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 5280 SOUTH EASTERN A6 LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H200	<p>Continued From page 10</p> <p>Setraline 50 mg.</p> <p>The record lacked documented evidence that the physician was notified of the change of dosage for the Niaspan and Bayer aspirin, Zoloft, Folic Acid, Vitamin D and multivitamins not on the POC.</p> <p>The registered nurse assigned to the patient was interviewed on 11/17/10 at 5:45 PM. The nurse stated she had never seen a copy of these progress notes. The nurse explained she had taken this patient over from another nurse and did not do the admission. The nurse stated the patient's wife determines what medications the patient would take.</p> <p>Scope: 3 Severity: 2</p>	H200			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.